

LICENSE APPLICATION SERVICE



COMPLETE & RETURN:

By Mail: Community Care Options

2580 Sierra Sunrise Terrace

Ste 110

Chico, CA 95928

By Fax: 530-894-2734

By Email: cco@communitycareoptions.com

DIRECTIONS:

We've attached 6 pages of information that we need you to fill out. Please fill out **all** fields to the best of your ability. If you aren't sure about a field, you can always call and ask us.

Please make sure that you are sending back the following things:

- 6 Pages attached
- Articles of Incorporation or Partnership Agreement (*if applicable*)
- Bank Statement
 - We need to be able to see the bank **name**, the bank **address**, the **account number**, and the **current balance**. We don't need the transaction history.
- Credit Report
 - This is **not** your credit score (3-digit number), but a larger document that shows all **open lines of credit**. If the licensee has no open lines of credit, we don't need this. Just let us know!
- Return to Community Care Options using one of the methods listed above.

Remember! If the licensee is a corporation, we need the 6 pages, bank statement, and credit report in the name of the corporation. If you are applying as an individual, we need those documents in your name.

If you have any questions about what we need or how it works, please call us anytime M-F 8-5 at (530) 894-2114. You can also email us at cco@communitycareoptions.com.

Thank you for choosing Community Care Options to assist in your license application process!

APPLICATION FOR A RESIDENTIAL CARE FACILITY

Please complete this form and return as soon as possible – See fax or email below.

1. Applicant Information

Full Name: _____

Email: _____

Phone #: _____ Cell #: _____

Fax #: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Application filed by (choose one): Individual Partnership Non-Profit Corporation
 Profit Corporation Limited Liability Corporation

If Corporation, please provide the following information:

Owner(s) (greater than 10% ownership)

1

Corporation Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone Number(s): _____

Name(s): _____

Address: _____

City: _____ State: _____ Zip: _____

Phone Number(s): _____

Name(s): _____

Address: _____

City: _____ State: _____ Zip: _____

Phone Number(s): _____



2580 Sierra Sunrise Terrace | Suite 110 | Chico, CA 95928
Phone: 530.894.2114 | Fax: 530.894.2734
cco@communitycareoptions.com

Name(s): _____

Address: _____

City: _____ State: _____ Zip: _____

Phone Number(s): _____

Officers

President

Name(s): _____

Address: _____

City: _____ State: _____ Zip: _____

Phone Number(s): _____

Vice-President

Name(s): _____

Address: _____

City: _____ State: _____ Zip: _____

Phone Number(s): _____

Secretary

Name(s): _____

Address: _____

City: _____ State: _____ Zip: _____

Phone Number(s): _____

Treasurer

Name(s): _____

Address: _____

City: _____ State: _____ Zip: _____

Phone Number(s): _____

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2. Facility Information

Facility Name: _____

Type of Facility: RCFE ARF Home Care Total Requested Capacity: _____

Facility Phone #: _____ # of Non-Ambulatory (if any): _____

Facility Address: _____

City: _____ State: _____ Zip: _____

County: _____ Administrator: _____

Property Ownership: Own Lease

If OWN, please complete below

Purchase Date: _____ Purchase Price: _____

Current Value: _____

Loans Associated with Facility

First \$ _____ Monthly Payment: \$ _____ Loan # _____

Second \$ _____ Monthly Payment: \$ _____ Loan # _____

Mortgage Company/Companies

Name: _____ Phone #: _____

Address: _____

Name: _____ Phone #: _____

Address: _____

If LEASE, please complete below

Monthly Payment: \$ _____

Property Owner(s) Name(s): _____

Property Owner(s) Address: _____

City: _____ State: _____ Zip: _____

Property Owner(s) Phone Number(s): _____

Was this facility previously licensed? Yes No

If yes, please provide the following:

Facility Name: _____

License #: _____



3

Source of Water for Human Consumption: Public Private

If you currently or previously own(ed) or manage(d) any residential care or health care facilities, please list information below:

Facility Name: _____

License #: _____

Facility Name: _____

License #: _____

Facility Name: _____

License #: _____

APPLICATION FOR A RESIDENTIAL CARE FACILITY – ADDITIONAL ASSETS

Other Real Estate or Land owned

<i>Please Print Legibly</i>	First Property	Second Property	Third Property
RCFE / House / Land			
Purchase Date			
Location: Full Address			
Purchase Price			
Current Value			
Mortgage Company			
Loan Number			
Mortgage Balance			
Monthly Payment			

Autos, Boats, or R.V.s owned

5

<i>Please Print Legibly</i>	First Auto	Second Auto	RV	Boat	Other
Make / Type					
Purchase Date					
Purchase Price					
Current Value					
Lender					
Loan Number					
Loan Balance					
Monthly Payment					

Credit Cards or Other Loans

Company	Payment	Balance	Company	Payment	Balance



PAYMENT and CREDIT CARD CHARGE AUTHORIZATION

Thank you for choosing Community Care Options for your education, training, and licensing needs. Before we can begin your application, payment is required. We accept Visa, MasterCard, Discover, and American Express. **Our fees are as follows:**

- **\$1,500 for 6 beds or less**
- **\$2,000 for 7 beds to 49 beds**
- **\$2,500 for 50+ beds**

Additional fees may apply for changes that are not required by Community Care Licensing Division.

Payment Information

Method of Payment (*Circle One*): Check Credit Card

Credit Card Type (*Circle One*): Visa MasterCard Discover Amex

Name as it Appears on Credit Card: _____

Credit Card #: _____

Expiration Date: CVN: Issuing Bank: _____

Credit Card Billing Address: _____

City, State, Zip: _____

By completing and signing this authorization form, the card holder acknowledges and understands that all authorized charges will be applied to the above credit card prior to beginning any services. Additionally, credit card charges may be applied to the above credit card prior to any changes which are not required by Community Care Licensing Division.

Community Care Options is authorized to charge \$ _____ to the above credit card.

My signature below hereby authorizes Community Care Options to charge the total amount noted above to my credit card. I understand that payment for services in non-refundable and credit will not be given for delivered applications that are not used. All sales are final.



Authorized Card Holder Signature

Date



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